Southeast Regional Trauma Coordination Committee
Funding and Repatriation Breakout Session – 9 January 2009

I GOALS

A. Definition of Trauma Patient is clearly defined across region – state

B. Able to track total cost/charges of trauma patient from scene to final disposition in the trauma system

C. Report both cost and charge information

D. By 2010 conduct pilot project to collect trauma costs across a jurisdiction/region

E. Describe a gap analysis of long term and rehabilitation resources in region

II ISSUES/BARRIERS

A. Need common definition of trauma patient used for regional/state comparisons

B. Unable to tract/connect trauma patient fiscal data from facility to facility

C. Inability to track trauma patient costs/charges at institutional/jurisdictional level

D. Resistance to sharing cost information

E. Differences in accounting practices and definitions

F. Long process time to establish governmental funding

G. Lack of understanding fiscal issues related to trauma patient acute care and post acute care. How per diem funding is shared between institutions if repatriating.

H. Insurance company challenges to trauma fees or diagnostic exams when repeated from initial facility.

I. Burn patients routinely are lengthy stays (weeks to months) but the Burn Centers are often not located in County of Residence and therefore do not receive county/local funding that would otherwise be available if located in County of Residence.

J. Managed Care/Insurance pressure to move trauma patient to a covered facility – often prior to patient being ready for transfer – need guidelines

K. Costs associated with trauma patient placement once ready for discharge from acute care

L. Costs associated with trauma patient repatriation with another acute care facility versus long term care or rehabilitation

M. Lack of understanding what the long term care or rehabilitation resources available in region

N. Lack of clear definition of what is meant by “repatriation”

O. Unable to show data on operational cost of a trauma service

P. Cross state line funding and insurance – other state trauma center may be closer.

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III POTENTIAL SOLUTIONS

A. Fiscal Tracking

1. Each Trauma Center establishes a tag for each trauma patient in the system – Clearly label
    a) Use a Code
    b) Use Charge Code entry (i.e. activation fee)
    c) Create a "no charge" code to identify cases after services provided but not seen directly by Trauma
    d) Establish billing code for walk-in patients that is acceptable by insurance companies
        (1) Establish state level insurance agreement
2. Establish a linking data field between trauma centers that is captured in the trauma registry to allow facility-to-facility tracking across jurisdictions
3. Establish similar account principles related to trauma patients

B. Cost of Trauma

1. Establish a "trauma service" by identify as a trauma product line at each trauma center
2. Establish a format and inclusion – exclusion criteria for the reporting the operational direct and indirect costs
3. Cost of trauma team/product line including but beyond "activation" (what does it take to have the resources available)
4. Capture date ready for transfer to another acute care and long-term/rehab care in registry and associated costs/charges for phases of care

C. Pilot Project

1. Conduct a pilot project collect trauma costs across a jurisdiction/region

D. Define who is a Trauma Patient

1. Not confused with Trauma Care Fund definition of trauma patient
2. Define what is a trauma patient, i.e.
    a) Use MTOS definition
    b) Separate ED Discharged, PH designated trauma patients
3. State/Regional definition

E. Managed Care Organizations

1. Establish policy/guideline/standard addressing criteria for transfer to non-trauma center insurance preferred facility that will ensure readiness of patient to be transferred.
2. Establish post-transfer quality feedback loop on progress and complication of patient to the transferring trauma center

F. REPATRIATION

1. ACUTE CARE –
    a) dependent on
        (1) Bed availability
        (2) Resource needs of patient
    b) Solutions
        (1) Provider reservations (pre-arranged, contractual)
        (2) Facility-to-facility agreements for cost recovery

2. SUB-ACUTE –
    a) Identify Case Managers at trauma centers
    b) Identify long-term care/rehab resources in region
    c) Shorten time to approve government funding
3. Burn Center
    a) Fiscal funding from sending jurisdiction

IV STRATEGY/TACTICS

A. Establish Critical Data Points across all trauma centers
B. Establish field that connects trauma patient between facilities
C. Inventory post acute facilities in region or immediately adjacent
D. Meet with fiscal representatives to better describe and define methodology for capture trauma data
E. Establish Pilot Project to capture trauma costs/charges

V STAKEHOLDERS

A. Additional stakeholders needed to accomplish above
1. Social services in county – contacts and services
2. Hospital discharge coordinators/case managers/etc to identify issues that are common and unique to trauma patients in post-acute care placement.
3. Skilled nursing facility/Rehab/long-term care associations or groups to confirm processes and issues related to trauma patient in region
4. Hospital fiscal staff to meet and discuss standardization of methodology for tracking, capture and defining the trauma product line

VI FUTURE STEPS

A. Clearly define “repatriation” statewide
B. Clearly define what the “trauma patient “ is
C. Survey fiscal managers (short < 10 question – what the issues are)
D. Recommend trauma centers establish a “trauma tag”
E. Do inventory of post-acute care resources